Document 6. What is a VBID Plan?

VBID plans are built on the principles of engaging your members in their health and well-being, and designing a benefit plan that 1) promotes wellness by emphasizing primary/preventive care; 2) lowers or removes financial barriers to essential, high-value clinical services; and 3) discourages the use of low-value health services and providers. VBID plans clearly communicate with their members and provide tools to allow members to use their health plan more effectively and efficiently.

VBID benefits are structured to offer rewards and incentives to members for being well and using the health care system efficiently. They align patients' out-of-pocket costs, such as copayments, with the value of services.

In Maryland, plans must contain the following elements in order to be considered a baseline VBID plan:

- At least three incentives to use high-value services. A high-value service is one that is accepted in the peer-reviewed literature as providing considerable clinical benefit, relative to the cost;[1]

- At least two incentives to promote wellness and health among members. Incentives may include promoting disease management programs, health assessments, biometric screenings, tobacco cessation, weight management programs, and other health behavior programs; and

- Targeting incentives and interventions to specific patient groups (e.g. those with chronic disease(s)).

Recognizing that many VBID plans evolve over time and slowly incorporate different incentives and disincentives, plans that contain the following element will receive a higher rating or recognition in the Exchange:

- At least one incentive to discourage low-value or unproven services. A low-value or unproven service is one that does not provide substantial health benefit relative to the cost.[2]

[1] Fendrick, A.M., Smith, D.G., and Chernew, M.E. Applying Value-Based Insurance Design to Low-Value Health Services. *Health Affairs* November 2010 29(11): 2018.
[2] Ibid.